

1266

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City | | | | c. LENGTH OF STAY IN 1b Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RED #2 | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Edna Middle B. Last Bishop | | | | 4. DATE OF DEATH Month January Day 10 Year 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 29, 1890 | |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66 | | IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min. 66 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John E. Brittingham | | | | 14. MOTHER'S MAIDEN NAME Mary Ann Dix | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. James Bishop, Baltimore, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 170 X DUE TO Carcinoma of Breast with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. metastases DUE TO metastases (c) metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) — | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 months 13 Oct 55 to 10 Jan 57 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11 March, 1949 , to 10 Jan, 1957 , that I last saw the deceased alive on 9 Jan, 1957 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE N. E. Sartorius, Jr. M.D. | | | | ADDRESS (Street, city or town, state) Pocomoke, Md. DATE SIGNED Jan 14 1957 | | | |
| PHYSICIAN'S NAME (Type) N. E. Sartorius, Jr. M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-13-57 | | 22c. NAME OF CEMETERY OR CREMATORY Pitts Creek Baptist Cem. | | 22d. LOCATION (City, town, or county) (State) Rural-Pocomoke City, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson | | | | ADDRESS Pocomoke, Md. | | 24a. REC'D BY REGISTRAR Jan 14 1957 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Gene White | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1267

CERTIFICATE OF DEATH

Reg. Dist. No.

012558

| | | | | | | | |
|---|------------------------------|---|---|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u> | | | | c. LENGTH OF STAY IN 1b <u>59 YRS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 OCEAN CITY</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>1 ST. LOUIS AVE</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>JACKSON</u> Last <u>BUNTING</u> | | | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>24</u> Year <u>1957</u> | | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>DEC. 15, 1869</u> | 9. AGE (In years last birthday) <u>87</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED WATERMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u> | | 11. BIRTHPLACE (State or foreign country) <u>BISHOPVILLE MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JAMES ROBIN BUNTING</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY SMITH.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>MRS. J. JACKSON BUNTING</u> Address <u>OCEAN CITY MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterio sclerosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Generalized A-S CUI</u> (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>54 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Aug</u> 19 <u>56</u> to <u>Jan 24</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 23</u> 19 <u>57</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> | | | | ADDRESS (Street, city or town, state) <u>Ocean City Md</u> DATE SIGNED <u>Jan 25 57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1/26/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Bunker Berlin</u> | | | | 24a. REC'D BY REGISTRAR <u>Jan 28 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Helene Z. Hayward</u> | |

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MAN 28 MAY 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1268

CERTIFICATE OF DEATH

01256

Reg. Dist. No.

351

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> | |
| c. LENGTH OF STAY IN 1b <u>3 1/2 years</u> | | d. STREET ADDRESS <u>1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Bara</u> Middle <u>Barton</u> Last <u>Barton</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Beland</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 15 - 1896</u> |
| 9. AGE (In years last birthday) <u>60 5/13</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>13</u> Hours <u>13</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Worcester, md</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Isaac Waters</u> | | 14. MOTHER'S MAIDEN NAME <u>Basie Wallick</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs Evelyn Mills</u> Address <u>Snow Hill, md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 DUE TO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardiovascular Disease</u> DUE TO (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11/10</u> , 19 <u>56</u> , to <u>1/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/17</u> , 19 <u>57</u> , and that death occurred at <u>6:04</u> A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas L. Jones, M.D.</u> | | ADDRESS (Street, city or town, state) <u>Snow Hill, Md.</u> DATE SIGNED <u>1/21/57</u> | |
| PHYSICIAN'S NAME (Type) <u>Thomas L. Jones M.D.</u> | | <u>Snow Hill, Md</u> <u>1/21/57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>Jan 21/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Good Springs Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Worcester, md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Harris</u> | | ADDRESS <u>Snow Hill, md</u> | |
| 24a. REC'D BY REGISTRAR <u>Wayne E. Harris</u> | | 24b. REGISTRAR'S SIGNATURE <u>Evelyn Cooper</u> | |

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INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ATSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG21- 2-1-57 et

CERTIFICATE OF DEATH

1264

Reg. Dist. No. 01257 350

| | | | | | | | |
|--|---------------------------|--|---------------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>WORCESTER</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Worcester</u> | | | |
| CITY OR TOWN <u>Pocomoke City</u> | | LENGTH OF STAY (in this place) <u>11 yrs</u> | | CITY OR TOWN <u>Pocomoke City</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u> | | | | STREET ADDRESS <u>R.F.D. # 2 Box 31</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>JAMES Edward Feddeman</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>1-13-1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>June 10, 1894</u> | 9. AGE last birthday <u>62</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Howard Feddeman</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>223-18-6519</u> | | 17. INFORMANT & ADDRESS <u>Violine Brown-Atlantic, Virginia</u> | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Essential Hypertension</u> | | | | <u>2 yrs</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Ed exhaustion</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> M. | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>7/27, 1955</u> , to <u>1/12, 1957</u> , that I last saw the deceased alive on <u>1/12, 1957</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Geil A. Juveny M.D.</u> | | | | ADDRESS (Street, city, town, state) <u>801 Fourth Street, Pocomoke City, Maryland</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>1/18/57</u> | | NAME OF CEMETERY OR CREMATORY <u>Wattsville Cem.</u> | | LOCATION (City, town, or county) (State) <u>Wattsville, Va.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE <u>Anne E. White</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> | | ADDRESS <u>New Church, Va.</u> | |
| DATE <u>Jan. 18, 1957</u> | | | | | | | |

21 JAN 21 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 10 days. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01258

Reg. Dist. No. 353

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BISHOPS | | | | c. LENGTH OF STAY IN 1b 59 yrs | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle WASHINGTON Last FLOYD | | | | 4. DATE OF DEATH Month January Day 21 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT. 2, 1897 | |
| 9. AGE (In years last birthday) 59 yrs. | | IF UNDER 1 YEAR Months 5 Days 17 | | IF UNDER 24 HRS. Hours 17 Min. 57 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAG DEALER | | | | 10b. KIND OF BUSINESS OR INDUSTRY FEED BAG | | 11. BIRTHPLACE (State or foreign country) BISHOP, MD | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME JAMES FLOYD | | | | 14. MOTHER'S MAIDEN NAME CHARLOTTE HOLLOWAY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. No | | | |
| 17. INFORMANT MRS. MAY BUNTING, WHALEYVILLE MD | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull 983x DUE TO Laceration of brain Conditions, if any, which gave rise to immediate cause (b) 983x DUE TO Laceration of brain (c) 983x DUE TO Laceration of brain PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 983x DUE TO Laceration of brain | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Assaulted by person(s) unknown | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour Abt. 1/15 to 1/17 p. m. 19 57 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard | | | | 20f. (City or town) Worcester (County) Bishops (nr. Berlin) (State) Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE R. S. Fisher | | | | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 1/22/57 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 1/24/57 | | 22c. NAME OF CEMETERY OR CREMATORY RED MENS | | 22d. LOCATION (City, town, or county) SELBYVILLE DEL (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbey | | | | 24. REG'D BY REGISTRAR 1957 25. REGISTRAR'S SIGNATURE Hilda R. Burbey | | | |

RECEIVED

JAN 24 1957

BUREAU V. S.

Yard

Apr. 1, 1957

Amended by person(s) unknown

Location of birth

Male

White

WASHINGTON

YOUTH

January

1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1270

CERTIFICATE OF DEATH

Reg. Dist. No.

0125955

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - Rt. #3</u> | | d. STREET ADDRESS <u>1 Route #3</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Howard</u> Last <u>Fooks</u> | | 4. DATE OF DEATH Month <u>1</u> - Day <u>22</u> - Year <u>1957</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>A. A</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1876</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Berlin, Worcester Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Henry Fooks</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT Address <u>Mrs. Esther White, Berlin, Md., Rt. #3</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260 (1) Diabetes mellitus, (2) Hypertensive C-V Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>2/10</u> , 19 <u>57</u> , to <u>1-22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>57</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Harry H. Snelly, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>Flower St. Berlin Md.</u> DATE SIGNED <u>1-22-57</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-25-57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Fooks Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Berlin, Worcester Co., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart Funeral Home, Salisbury, Md.</u> | | ADDRESS <u>Flower St. Berlin Md.</u> DATE <u>JAN 24 1957</u> | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <u>Robert L. Hayward</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 24 1957

RECEIVED

1265

CERTIFICATE OF DEATH

Reg. Dist. No.

01260
350

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| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City | | c. LENGTH OF STAY IN 1b 28 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 4th Street | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City | |
| 3. NAME OF DECEASED (Type or print) First William Middle T. Last Hill | | 4. DATE OF DEATH Month January Day 9 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 14, 1890 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John W. Hill | | 14. MOTHER'S MAIDEN NAME Mary Strong | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 215-10-7335 | |
| 17. INFORMANT Mrs Clara E. Hill, Pocomoke City, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | INTERVAL BETWEEN ONSET AND DEATH 14 Hours 3 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 9, 1950 to Jan. 9, 1957 , that I last saw the deceased alive on Jan. 9, 1957 , and that death occurred at 653 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Charles W. Trader | | ADDRESS (Street, city or town, state) 302 Market St., Pocomoke City, Md. DATE SIGNED 1-11-57 | |
| PHYSICIAN'S NAME (Type) Charles W. Trader, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 1-12-57 | 22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery | 22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Watson | | 24a. REC'D BY REGISTRAR Jan 14 1957 24b. REGISTRAR'S SIGNATURE Barre White | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01261

Reg. Dist. No. 355

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| 1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u> c. LENGTH OF STAY IN 1b <u>44 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u> x2 d. STREET ADDRESS <u>BALTIMORE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LEVIN</u> Middle <u>DAVID</u> Last <u>LYNCH</u> | | | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>10</u> Year <u>1957</u> | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MAY 17, 1912</u> | | 9. AGE (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FISH BROKER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE FISH DOCK</u> | | 11. BIRTHPLACE (State or foreign country) <u>OCEAN CITY MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>L.D. LYNCH SR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>BETTY KELLY</u> | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u> | | 17. INFORMANT Address <u>MR. L.D. LYNCH SR. OCEAN CITY, MD</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Arteriosclerosis and Atherosclerosis</u> (b) <u> </u> (c) <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown sudden.</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Hermon A. Robbins</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) | | | | DATE SIGNED <u>1/12/57</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1/12/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u> | | | | ADDRESS <u>Berlin Md</u> | | 24a. REC'D BY REGISTRAR <u>DATE 1/15/57</u> | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u> | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WILSON
DOGAN CITY
L. D. - Y. C. - 21
From Brother
MALE WHITE
L. D. - Y. C. - 21
BETTY L. D. - Y. C. - 21
DOGAN CITY MO
MAY 1912
L. D. - Y. C. - 21
DOGAN CITY MO
L. D. - Y. C. - 21
DOGAN CITY MO

Genie Coranany Johnston
Coranany Johnston

Genie Coranany Johnston

BUREAU V. S.

JAN 16 1957

RECEIVED

Mr. C. L. Johnson

1272

CERTIFICATE OF DEATH

Reg. Dist. No. 357

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| 1. PLACE OF DEATH o. COUNTY Worcester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton | | | | c. LENGTH OF STAY IN 1b x2 Stockton | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home | | | | d. STREET ADDRESS P.O. Box 137 | | | |
| 3. NAME OF DECEASED (Type or print) Nancy First Middle Marshall Last | | | | 4. DATE OF DEATH Jan 13 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 13, 1890 | 9. AGE (In years lost birthday) yrs. 66 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Housework | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Saunders Horsey | | | | 14. MOTHER'S MAIDEN NAME Lovie Brittingham | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Rubin Marshall - Stockton, md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary Thrombosis DUE TO (b) Diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-30-57, 19, to 1-31-57, 19, that I last saw the deceased alive on 1-30-57, 19, and that death occurred at 8:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Paul Cohen M.D. Snow Hall Md ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) PAUL COHEN | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Feb. 3, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Stockton Cem. | | 22d. LOCATION (City, town, or county) (State) Stockton, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - New Church, Va. | | | | 24a. REC'D BY REGISTRAR DATE 2/6/57 | | 24b. REGISTRAR'S SIGNATURE Clayton B. Cooper | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

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|------------------|--|-----|--|-----|--|---------------|--|----------------|--|-----------------|--|----------------|--|---------------|--|---------------|--|----------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Manner of Death | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Physician | | Signature of Registrar | |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1273

CERTIFICATE OF DEATH

Reg. Dist. No.

01262
353

| | | | | | | | |
|--|---------------------------------|--|--------------------------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Worcester</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | | | | c. LENGTH OF STAY IN 1b <u>life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. STREET ADDRESS <u>R.D. 2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>McGregor</u> Last <u>McGregor</u> | | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1957</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 1, 1874</u> | 9. AGE (In years last birthday) <u>82</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Berlin, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William Smack</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Pudeant</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT <u>Ethel Collins</u> Address <u>Berlin, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardio-vascular disease</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Sept 5, 1957</u> to <u>Jan 19, 1957</u> , that I last saw the deceased alive on <u>Jan 19, 1957</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Lois U. Shuler Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Johns St Berlin Md</u> DATE SIGNED <u>1/21/57</u> | | | |
| PHYSICIAN'S NAME (Type) _____ | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Jan. 23, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Longgreen</u> | | 22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>1/23/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Helda Beggs</u> | |

CERTIFICATE OF DEATH

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|------------------------|--|------------------------|--|
| NAME OF DECEASED | | DATE OF DEATH | |
| SEX | | AGE | |
| RACE | | EDUCATION | |
| MARRIAGE | | OCCUPATION | |
| PLACE OF BIRTH | | PLACE OF DEATH | |
| DATE OF BIRTH | | DATE OF DEATH | |
| TIME OF DEATH | | CAUSE OF DEATH | |
| MANNER OF DEATH | | PLACE OF INTERMENT | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | |
| SIGNATURE OF MINISTER | | SIGNATURE OF CLERGYMAN | |
| SIGNATURE OF JUDGE | | SIGNATURE OF SHERIFF | |
| SIGNATURE OF CLERK | | SIGNATURE OF RECORDS | |
| SIGNATURE OF DECEASED | | SIGNATURE OF WITNESSES | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF CORONER | |
| SIGNATURE OF MINISTER | | SIGNATURE OF CLERGYMAN | |
| SIGNATURE OF JUDGE | | SIGNATURE OF SHERIFF | |
| SIGNATURE OF CLERK | | SIGNATURE OF RECORDS | |

BUREAU Y. E.

JAN 25 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 355

| | | | |
|---|----------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u> | | c. LENGTH OF STAY IN 1b <u>3 mo.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Whaleyville - Rural</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Barbara</u> First <u>Anne</u> Middle <u>Morgan</u> Last | | 4. DATE OF DEATH <u>Jan 10 19 57</u> Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>wt</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 7/56</u> |
| 9. AGE (In years last birthday) <u>8</u> yrs. <u>13</u> Months <u>13</u> Days | | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 MRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Barny James Morgan</u> | | 14. MOTHER'S MAIDEN NAME <u>Ethel Mae Jooney</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Ethel Mae Morgan</u> Address <u>Whaleyville, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probably Pneumonia</u> DUE TO <u>neglected cold</u> Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Infantile Hydrocephalus - also Perforation of jejunum</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>W.E. Sartorius</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>W.E. Sartorius</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>1/13/57</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A Burbage</u> | | ADDRESS <u>Berlin Md</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE 1/15/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Helen L. Hayward</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1275

CERTIFICATE OF DEATH

Reg. Dist. No.

01264

355

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|---|---------------------------|---|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Worcester MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville | | c. LENGTH OF STAY IN 1b life | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Whaleyville | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | d. STREET ADDRESS / | |
| 3. NAME OF DECEASED (Type or print) First H. Middle LEE Last NIBLETT | | 4. DATE OF DEATH Month Jan. 19 Year 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 6, 1874 |
| 9. AGE (In years last birthday) yrs. 62 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Chicken | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry S. Niblett | | 14. MOTHER'S MAIDEN NAME Mary Jane Truitt | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. 214-34-7267 | |
| 17. INFORMANT Mrs. Lizzie Niblett | | Address Whaleyville, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Hypertension. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH 6 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 13, 1957, to 1-19, 1957, that I last saw the deceased alive on 1-19-57, 19 and that death occurred at 4 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Frank Lewis | | ADDRESS (Street, city or town, state) Wellards Maryland | |
| DATE SIGNED | | DATE | |
| PHYSICIAN'S NAME (Type) | | DATE | |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial | | 22b. DATE THEREOF 1/22/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Dale | | 22d. LOCATION (City, town, or county) (State) Whaleyville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Peter Whaley Selbyville, Del. | | 24a. REC'D BY REGISTRAR AN 23 1957 | |
| 24b. REGISTRAR'S SIGNATURE Robert F. Hayward | | DATE | |

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1276

CERTIFICATE OF DEATH

Reg. Dist. No.

01265351

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| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Route #2</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Snow Hill Route #2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Margie</u> Middle <u>Y.</u> Last <u>Pennewell</u> | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>22</u> Year <u>1957</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 30-1898</u> |
| 9. AGE (In years last birthday) <u>58 1/2</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>23</u> Days <u>13</u> Hours <u>13</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Minna, Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Edward E. Jacob</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Byrd</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Mrs. M. M. Pennewell</u> | | Address <u>Snow Hill, md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia and Emaciation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CAPILLARY CYSTADENOCARCINOMA OF THE OVARY WITH ABDOMINAL METASTASES</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>1 YR</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) INTESTINAL OBSTRUCTION (2) RECTO VAGINAL FISTULA</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>APRIL 15, 1956</u> , to <u>JAN 22, 1957</u> , that I last saw the deceased alive on <u>January 21, 1957</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert C. La Mar</u> | | ADDRESS (Street, city or town, state) <u>104 Bay St</u> | |
| PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u> | | DATE SIGNED <u>1-22-57</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 24/57</u> | | 22b. DATE THEREOF <u>Bates Memorial</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Snow Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer Cooper</u> | | ADDRESS <u>Snow Hill, md</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 24 1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Elmer Cooper</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | | 7. CAUSE OF DEATH | | 8. PLACE OF DEATH | | 9. DATE OF DEATH | | 10. TIME OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | |
| 13. MANNER OF DEATH | | 14. PLACE OF INTERMENT | | 15. NAME OF INTERMENT | | 16. DATE OF INTERMENT | | 17. TIME OF INTERMENT | | 18. SIGNATURE OF INTERMENT | | 19. SIGNATURE OF REGISTRAR | | 20. SIGNATURE OF PHYSICIAN | | 21. SIGNATURE OF REGISTRAR | | 22. SIGNATURE OF PHYSICIAN | | 23. SIGNATURE OF REGISTRAR | | 24. SIGNATURE OF PHYSICIAN | |
| [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | | [REDACTED] | |

BUREAU V. S.

JAN 24 1957

RECEIVED

1277

CERTIFICATE OF DEATH

Reg. Dist. No.

355

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY Worcester MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin | | | | c. LENGTH OF STAY IN 1b All life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home - Maple Ave. | | | | d. STREET ADDRESS Maple Ave. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Julia Middle Margaret Last Pitts | | | | 4. DATE OF DEATH Month 1 Day 29 Year 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE A.A. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-15-1902 | |
| 9. AGE (In years lost birthday) 54 yrs. | | IF UNDER 1 YEAR Months 8 Days 14 Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Chicken Plant | | 11. BIRTHPLACE (State or foreign country) Berlin, Worcester Co. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Daniel Showell | | | | 14. MOTHER'S MAIDEN NAME Mahala Purnell | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-09-2804 | | 17. INFORMANT Address Leroy Pitts, Maple Ave. Berlin, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia bilateral 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) atelectasis DUE TO (c) possible bronchogenic carcinoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) heart INTERVAL BETWEEN ONSET AND DEATH 3 weeks ? ? | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Nov 19 56 , to Jan 29 19 57 , that I last saw the deceased alive on Jan 29 19 57 , and that death occurred at 1:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Berlin, Md. DATE SIGNED 1/31/57 | | | | | | | |
| ACTUAL SIGNATURE Robert A. Grubb M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) ROBERT A. GRUBB, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-2-57 | | 22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery | | 22d. LOCATION (City, town, or county) (State) Berlin, Worcester Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md. | | | | ADDRESS | | 24a. REC'D BY REGISTRAR FEB 4 1957 | |
| 24b. REGISTRAR'S SIGNATURE Helen F. Hayward | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01267

1278

CERTIFICATE OF DEATH

Reg. Dist. No.

351

| | | | | | | | |
|---|---------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WOR.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) <u>BRENDA MAE PURNELL</u> | | | | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>27</u> Year <u>1957</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 19, 1957</u> | 9. AGE (In years lost birth day) <u>4 days</u> | IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | | | | | | |
| 13. FATHER'S NAME <u>CHARLES E. PURNELL</u> | | | | 14. MOTHER'S MAIDEN NAME <u>NAOMI TINDLEY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u> | | | | 16. SOCIAL SECURITY NO. <u>-</u> | | | |
| 17. INFORMANT <u>MR. CHARLES E. PURNELL</u> | | | | Address <u>NEWARK MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diarhea</u> <u>764.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>1-19-1957</u> to <u>1-27-1957</u> , that I last saw the deceased alive on <u>1-27-1957</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Ivory N. Sney Jr</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Flower St. Berlin md</u> | | | |
| DATE SIGNED <u>1/28/57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u> | | 22b. DATE THEREOF <u>1/28/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS (Col.)</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Diana D. Purby</u> | | | | ADDRESS <u>Berlin md</u> | | 24a. REC'D BY REGISTRAR <u>AN 30 1957</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Theresa Cooper</u> | | | | | | | |

JAN 30 1957

RECEIVED

1279

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | | c. LENGTH OF STAY IN 1b <u>Most of life</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home - Route #2</u> | | | | d. STREET ADDRESS <u>Route #2</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Whaley</u> Last <u>Purnell</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>AA</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Dec 12 1910</u> | | 9. AGE (In years last birthday) yrs. <u>46</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Berlin, Worcester Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Jacob Purnell</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Julia Whaley</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>no</u> | | 17. INFORMANT <u>Mrs. Pauline Purnell - Berlin, Md. Rt. #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion acute</u> <u>420.1</u> DUE TO <u>R.H.D. - multiple valvular defects with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>long standing decompensation</u> (c) <u>long standing decompensation</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1954</u> , 19 <u>56</u> , to <u>Jan 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>56</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>F. J. Townsend Jr.</u> | | | | ADDRESS (Street, city or town, state) <u>Ocean City, Md.</u> | | DATE SIGNED <u>Jan 26, 56</u> | |
| PHYSICIAN'S NAME (Type) <u>F. J. TOWNSEND JR</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-28-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Berlin Worcester Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | | | ADDRESS | | 24a. REC'D BY REGISTRAR DATE <u>JAN 30 1957</u> | |
| | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Robert Hayward</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-1-54

| | | | | | | | | | |
|---------------------------|--|----------------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF BIRTH | |
| 6. PLACE OF BIRTH | | 7. OCCUPATION | | 8. CAUSE OF DEATH | | 9. MANNER OF DEATH | | 10. DATE OF DEATH | |
| 11. PLACE OF DEATH | | 12. SIGNATURE OF PHYSICIAN | | 13. SIGNATURE OF REGISTRAR | | 14. SIGNATURE OF WITNESS | | 15. SIGNATURE OF DECEASED | |
| 16. SIGNATURE OF DECEASED | | 17. SIGNATURE OF DECEASED | | 18. SIGNATURE OF DECEASED | | 19. SIGNATURE OF DECEASED | | 20. SIGNATURE OF DECEASED | |
| 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF DECEASED | | 23. SIGNATURE OF DECEASED | | 24. SIGNATURE OF DECEASED | | 25. SIGNATURE OF DECEASED | |
| 26. SIGNATURE OF DECEASED | | 27. SIGNATURE OF DECEASED | | 28. SIGNATURE OF DECEASED | | 29. SIGNATURE OF DECEASED | | 30. SIGNATURE OF DECEASED | |
| 31. SIGNATURE OF DECEASED | | 32. SIGNATURE OF DECEASED | | 33. SIGNATURE OF DECEASED | | 34. SIGNATURE OF DECEASED | | 35. SIGNATURE OF DECEASED | |
| 36. SIGNATURE OF DECEASED | | 37. SIGNATURE OF DECEASED | | 38. SIGNATURE OF DECEASED | | 39. SIGNATURE OF DECEASED | | 40. SIGNATURE OF DECEASED | |
| 41. SIGNATURE OF DECEASED | | 42. SIGNATURE OF DECEASED | | 43. SIGNATURE OF DECEASED | | 44. SIGNATURE OF DECEASED | | 45. SIGNATURE OF DECEASED | |
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| 56. SIGNATURE OF DECEASED | | 57. SIGNATURE OF DECEASED | | 58. SIGNATURE OF DECEASED | | 59. SIGNATURE OF DECEASED | | 60. SIGNATURE OF DECEASED | |
| 61. SIGNATURE OF DECEASED | | 62. SIGNATURE OF DECEASED | | 63. SIGNATURE OF DECEASED | | 64. SIGNATURE OF DECEASED | | 65. SIGNATURE OF DECEASED | |
| 66. SIGNATURE OF DECEASED | | 67. SIGNATURE OF DECEASED | | 68. SIGNATURE OF DECEASED | | 69. SIGNATURE OF DECEASED | | 70. SIGNATURE OF DECEASED | |
| 71. SIGNATURE OF DECEASED | | 72. SIGNATURE OF DECEASED | | 73. SIGNATURE OF DECEASED | | 74. SIGNATURE OF DECEASED | | 75. SIGNATURE OF DECEASED | |
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| 86. SIGNATURE OF DECEASED | | 87. SIGNATURE OF DECEASED | | 88. SIGNATURE OF DECEASED | | 89. SIGNATURE OF DECEASED | | 90. SIGNATURE OF DECEASED | |
| 91. SIGNATURE OF DECEASED | | 92. SIGNATURE OF DECEASED | | 93. SIGNATURE OF DECEASED | | 94. SIGNATURE OF DECEASED | | 95. SIGNATURE OF DECEASED | |
| 96. SIGNATURE OF DECEASED | | 97. SIGNATURE OF DECEASED | | 98. SIGNATURE OF DECEASED | | 99. SIGNATURE OF DECEASED | | 100. SIGNATURE OF DECEASED | |

BUREAU V. B.

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **0126450**

| | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------------------|--|---|--|---|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester Co</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke River 3 mo</u> c. LENGTH OF STAY IN lb <u>3 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1 Buck Kilm</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x0 Beaver Dam</u> d. STREET ADDRESS <u>1 Buck Kilm</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Ike</u> Middle <u>Stanford</u> Last <u>R</u> | | | | 4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1957</u> | | | | | | | | | | | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>C</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept 27-56</u> | | 9. AGE (In years last birthday) <u>3</u> yrs. <u>20</u> months <u>20</u> days <u>20</u> hours <u>20</u> min. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Ike Stanford Sr.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Betty - Joe Tyson</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) <input checked="" type="checkbox"/> | | | | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | | | | 17. INFORMANT <u>Betty Joe Tyson - Pocomoke, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>772.0</u> DUE TO <u>Congenital Debility</u> Conditions, if any, which gave rise to immediate cause (b) <u>Wasting & Malnutrition</u> (c) <u>Wasting & Malnutrition</u> (c) <u>Wasting & Malnutrition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Wasting & Malnutrition</u> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>254</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>N.E. Sartorius Sr.</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>1-17-57</u> | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>N.E. Sartorius</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>1-19-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>R.B. Wharton Memorial</u> | | | | 22d. LOCATION (City, town, or county) <u>Pocomoke, VA</u> | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> | | | | | | ADDRESS <u>new church, VA</u> | | 24a. REC'D BY REGISTRAR <u>1/18/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Anne E. White</u> | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---------------------|--|---------------|--|----------------|--|-----------------|--|------------------|--|-------------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF DEATH | | PLACE OF DEATH | |
| JAMES H. HARRIS | | 45 | | M | | W | | JAN 21 1957 | | BALTIMORE, MARYLAND | |
| RESIDENT OF | | OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | MEDICAL HISTORY | | POST-MORTEM EXAMINATION | |
| BALTIMORE, MARYLAND | | LABORER | | HEART DISEASE | | NATURAL | | NO | | NO | |
| DATE OF BIRTH | | DATE OF DEATH | | TIME OF DEATH | | TEMPERATURE | | PULSE | | BLOOD PRESSURE | |
| JAN 21 1957 | | JAN 21 1957 | | 10:30 AM | | 98.6 | | 72 | | 120/80 | |
| PLACE OF BIRTH | | EDUCATION | | RELIGION | | MARITAL STATUS | | PREVIOUS ILLNESS | | TREATMENT | |
| BALTIMORE, MARYLAND | | HIGH SCHOOL | | CATHOLIC | | MARRIED | | NO | | NO | |
| DATE OF MARRIAGE | | DATE OF DEATH | | TIME OF DEATH | | TEMPERATURE | | PULSE | | BLOOD PRESSURE | |
| JAN 21 1957 | | JAN 21 1957 | | 10:30 AM | | 98.6 | | 72 | | 120/80 | |
| PLACE OF MARRIAGE | | EDUCATION | | RELIGION | | MARITAL STATUS | | PREVIOUS ILLNESS | | TREATMENT | |
| BALTIMORE, MARYLAND | | HIGH SCHOOL | | CATHOLIC | | MARRIED | | NO | | NO | |

BUREAU V. B.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1281

CERTIFICATE OF DEATH

Reg. Dist. No.

012751

| | | | | | | | | | | | |
|---|--|----------------------------------|---|--|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> | | | c. LENGTH OF STAY IN 1b <u>73 yrs</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x0 Snow Hill</u> | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>1</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>G.</u> Last <u>Sturgis</u> | | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>27</u> Year <u>1957</u> | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 20 - 1883</u> | | 9. AGE (In years last birthday) <u>73 1/2</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Snow Hill, MD</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>MD</u> | | |
| 13. FATHER'S NAME <u>Albert Banner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Jones</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mr Thomas L Sturgis, Snow Hill, MD</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Acute Coronary Thrombosis</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u> <u>diabetes mellitus</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____ | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | |
| 21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>57</u> , to <u>Jan 27</u> , 19 <u>57</u> . that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>57</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St Snow Hill, MD</u> | | | | | | | | DATE SIGNED <u>1/29/57</u> | | | |
| ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>Robert C. La Mar, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 30 1957</u> | | | | 22b. DATE THEREOF <u>Jan 30 1957</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Walco Cemetery</u> | | 22d. LOCATION (City, town or county) (State) <u>Snow Hill MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Thomas</u> | | | | ADDRESS <u>Snow Hill, MD</u> | | | | 24a. REC'D BY REGISTRAR <u>1/31/1957</u> | | 24b. REGISTRAR'S SIGNATURE <u>Glwyn Coopers</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------|--|--|--|--|--|--|--|--|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES EARL RAY | | MALE | | 35 | | JAN 5 1928 | | MOBILE, ALABAMA | |
| OCCUPATION | | CAUSE OF DEATH | | MANNER OF DEATH | | PLACE OF DEATH | | DATE OF DEATH | |
| SALES MAN | | HEART DISEASE | | NATURAL | | HOSPITAL | | JAN 31 1968 | |
| PREVIOUS ILLNESS | | MEDICAL HISTORY | | HISTORY OF PRESENT ILLNESS | | HISTORY OF PRESENT ILLNESS | | HISTORY OF PRESENT ILLNESS | |
| NONE | | NONE | | NONE | | NONE | | NONE | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF DEATH CERTIFICATE OFFICER | | SIGNATURE OF DEATH CERTIFICATE OFFICER | | SIGNATURE OF DEATH CERTIFICATE OFFICER | | SIGNATURE OF DEATH CERTIFICATE OFFICER | |
| [Signature] | | [Signature] | | [Signature] | | [Signature] | | [Signature] | |
| DATE | | DATE | | DATE | | DATE | | DATE | |
| JAN 31 1968 | | JAN 31 1968 | | JAN 31 1968 | | JAN 31 1968 | | JAN 31 1968 | |

RECEIVED
JAN 31 1968
BUREAU V. S.

VS. A15ME(5)
SM 9/55

351

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|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Worcester | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Girardetree | | c. LENGTH OF STAY IN 1b 2 HOURS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS 614 Market Street | |
| 3. NAME OF DECEASED (Type or print) First Rixom Middle F. Last Taylor | | 4. DATE OF DEATH Month January Day 30 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 11, 1873 |
| 9. AGE (in years last birthday) 83 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brick Mason | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Rixom F. Taylor | | 14. MOTHER'S MAIDEN NAME Mary Aylesworth | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs Bertie B. Taylor, Pocomoke, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Disease Conditions, if any, which gave rise to immediate cause (b) Too strenuous activity for his disease (c) Too strenuous activity for his disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Too strenuous activity for his disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE N. E. Sartorius, Sr. | | DATE SIGNED 1/30/57 | |
| EXAMINER'S NAME (Type) N. E. Sartorius, Sr. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-2-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery | | 22d. LOCATION (City, town, or county) (State) Rural Pocomoke, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Dwight Watson | | 24a. REC'D BY REGISTRAR 1957 | |
| ADDRESS Pocomoke, Md. | | 24b. REGISTRAR'S SIGNATURE Elmer Coopers | |

RECEIVED

FEB 4 1957

BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **350**

01272

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pocomoke</u> c. LENGTH OF STAY IN 1b <u>5 yrs x 0 Rural - Pocomoke City</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Thornton</u> Middle <u>Thornton</u> Last <u>Thornton</u> 4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>19-57</u> | | | | 5. SEX <u>2</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Jan 27-57</u> 9. AGE (In years last birthday) <u>3</u> IF UNDER 1 YEAR Months <u>3</u> IF UNDER 24 HRS. Hours <u>3</u> Mins <u>3</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME <u>James Otis Thornton</u> 14. MOTHER'S MAIDEN NAME <u>Mildred McBrude</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>MD</u> 17. INFORMANT <u>Mildred Thornton Pocomoke City, MD</u> Address <u>Pocomoke City, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth</u> DUE TO (b) <u>776x</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>minutes</u> DUE TO (c) | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lack of Post natal care</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>o. m.</u> <u>p. m.</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>N E. Sutorius</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>N E. Sutorius</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>1/27/57</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>1-30-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem.</u> 22d. LOCATION (City, town, or county) <u>Pocomoke MD</u> (State) | | | | 24a. REC'D BY REGISTRAR <u>1/30/57</u> 24b. REGISTRAR'S SIGNATURE <u>Anne E. White</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - new church, Va.</u> ADDRESS | | | | 24c. REC'D BY REGISTRAR <u>1/30/57</u> 24d. REGISTRAR'S SIGNATURE | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral home. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 1 1957

RECEIVED